Medicaid fiscal agent, shall be used. Should none of the above sources provide acceptable information, the hospital shall be excluded from the reimbursement ceiling calculations. The hospital shall then have a rate assigned that equals the lowest computed rate in the county in which the hospital is located, or the lowest rate in the AHCA District in which the hospital is located, if there are no other hospitals in the county in question.

F. For subsequent periods, all cost reports received by AHCA as of each April 15 and October 15 shall be used to establish the reimbursement ceilings.

G. The individual hospital's prospectively determined rate shall be adjusted only under the following circumstances:

1. An error was made by the fiscal intermediary or AHCA in the calculation of the hospital's rate.

2. A hospital submits an amended cost report to supersede the cost report used to determine the rate in effect. There shall be no change in rate if an amended cost report is submitted beyond 3 years of the effective date the rate was established, or if the change is not material.

3. Further desk or field audits of cost reports used in the establishment of the prospective rate disclose material changes in these reports. For cost reports received on or after October 1, 2003, all desk or onsite audits of these cost reports shall be final and shall not be reopened past three years of the date that the audit adjustments are noticed through a revised per diem rate completed by the Agency.

Exception to the above mentioned time limit:

The aforementioned limitation shall not apply when Medicare audit reopenings result in the issuance of revised Medicaid cost report schedules. A cost report may be reopened for inspection, correction, or referral to a law enforcement agency at any time by the Agency or its contractor if program payments appear to have been obtained by fraud, similar fault, or abuse.

4. Where the charge structure of a hospital changes and the application of the lower of cost or charges limitations is reconsidered.

H. Any rate adjustment or denial of a rate adjustment by AHCA may be appealed by the provider in accordance with Rule 28-106, F.A.C., and Section 120.57 Florida Statutes.

I. Under no circumstances shall any rate adjustment exceed the reimbursement ceiling established, except as provided for in IV B.

J. In accordance with Section 2302 of Public Law 98-369, the Deficit Reduction Act of 1984, the reimbursement rates for laboratory and pathology services shall be the lower of: the hospital's charges or; the Medicaid fee schedule technical component as provided for in Rule 59G-4.160, F.A.C.

V. Method

This section defines the methodologies to be used by the Florida Medicaid Program in establishing reimbursement ceilings and individual hospital reimbursement rates.

A. Setting Reimbursement Ceilings.

1. Review and adjust the hospital cost report available to AHCA as of each April 15 and October 15 as follows:
   a. To reflect the results of desk or field audits.
   b. To reduce the Medicaid outpatient costs and charges for laboratory and pathology costs and charges.
2. Reduce a hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.9 (2000).
3. Determine Medicaid outpatient variable costs defined in Section X.
4. Adjust Medicaid outpatient variable costs for the number of months between the midpoint of the hospital's fiscal year and either September 30, or March 31, the midpoint of the rate semester for which the new rate is being calculated. The adjustment shall be made utilizing the latest available projections as of March 31 or September 30 for the Data Resources Incorporated (DRI) Type Hospital Market Basket Index as detailed in Appendix B.
5. Divide the inflated Medicaid outpatient variable costs by the latest available Health Care component of the Florida Price Level Index (FPLI) for the county in which the hospital is located.
6. Divide the results of Step 5 for each hospital by its total Medicaid outpatient occasions of service excluding occasions of service for laboratory and pathology resulting in an occasions of service rate.
7. Array the occasions of service rates in Step 6 from the lowest to the highest rate with the associated occasions of service.

8. Establish the reimbursement ceilings as the lower of:

a. The cost based ceilings for variable costs per occasion of service at the occasion of service rate associated with the 80th percentile of occasions of service, times the FPLI component utilized in Step 5 for the county in which the hospital is located. Rural and specialized psychiatric hospitals are excluded from the calculation and application of this cost based ceiling.

The following types of hospitals are included in the calculation but are exempt from the application of this cost based ceiling:

i. statutory teaching hospitals

ii. specialized hospitals

iii. Community Hospital Education Program (CHEP)

iv. Those mentioned in 9 and 10 below

v. Hospitals with Level III Neonatal Intensive Care Units that have a minimum of three of the following designated tertiary services as regulated under the certificate of need program: pediatric bone marrow transplantation, pediatric open heart surgery, pediatric cardiac catheterization and pediatric heart transplantation.

For hospitals participating in the Florida Medicaid Program that are located out of State, the FPLI used shall be equal to 1.00.

b. For rate periods beginning with the July 1,1993 rate period, the target ceiling shall be calculated by multiplying the previous rate period's ceiling by the target inflation factor as calculated in the following formula:

$$1 + 1.4 \times \left[\frac{\text{Midpoint of the prospective rate period using appendix B}}{\text{Midpoint of the current rate period using Appendix B}} - 1 \right]$$

This target ceiling shall not apply to rural, specialized ,statutory teaching, Community Hospital Education Program (CHEP) hospitals, and those hospitals defined in 9 and 10 below.

This target ceiling shall not apply to the following:

i. statutory teaching hospitals

ii. specialized hospitals

iii. Community Hospital Education Program (CHEP)

iv. Those mentioned in 9 and 10 below

v. Hospitals with Level III Neonatal Intensive Care Units that have a minimum of three of the following designated tertiary services as regulated under the certificate of need program: pediatric bone marrow transplantation, pediatric open heart surgery, pediatric cardiac catheterization and pediatric heart transplantation.

9. Effective July 1, 2001, outpatient reimbursement ceilings will be eliminated for hospitals whose charity care and Medicaid days as a percentage of total hospital days equals or exceeds fifteen percent. Effective July 1, 2002, the fifteen percent (15%) will be changed to fourteen and one-half percent (14.5%). The Agency shall use the disproportionate share hospital 1997 audited data available as of March 1, 2001 to determine eligibility for the elimination of ceilings. Effective July 1, 2003, the fourteen and one-half percent (14.5%) will be changed to eleven percent (11%) to eliminate the outpatient reimbursement ceilings for hospitals whose charity care and Medicaid days as a percentage of total adjusted hospital days equals or exceeds 11 percent. The Agency will use the average of the 1998, 1999, and 2000 audited DSH data available as of March 1, 2004. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency will use the average of the audited DSH data for 1998, 1999 and 2000 that is available. Hospital outpatient rates set under plan provisions for the July 1, 2003 rate semester will be effective October 1, 2003.

10. Effective July 1, 2001, outpatient reimbursement ceilings will be eliminated for hospitals whose Medicaid days as a percentage of total hospital days exceed 9.6% and are a trauma center. The Agency shall use

the 1997 audited DSH data available as of March 1, 2001 to determine eligibility for the elimination of ceilings. Effective July 1, 2003, outpatient reimbursement ceilings will be eliminated for hospitals whose Medicaid days, as a percentage of total hospital days, exceed 9.6 percent, and are trauma centers. The agency will use the average of the 1998, 1999, and 2000 audited DSH date available as of March 1, 2004. In the event the Agency does not have the prescribed three years of audited DSH data for a hospital, the Agency will use the average of the audited DSH data for 1998, 1999 and 2000 that is available. Hospital outpatient rates set under plan provisions for the July 1, 2003 rate semester will be effective October 1, 2003.

B. Setting Individual Hospital Rates.

1. Review and adjust the hospital cost report as follows:

   a. To reflect the results of desk and field audits.

   b. To reduce the Medicaid outpatient costs and charges for laboratory and pathology costs and charges.

2. Reduce the hospital's general routine operating costs if they are in excess of the limitations established in 42 CFR 413.30 (2000).

3. Determine Medicaid outpatient variable costs as defined in Section X.

4. Adjust Medicaid outpatient variable costs for the number of months between the midpoint of the hospital's fiscal year and September 30 or March 31, the midpoint of the following rate semester. The adjustment shall be made utilizing the DRI Regional Hospital Input Price Index as detailed in Appendix B.

5. Establish the variable cost rate as the lower of:

   a. The inflated rate by dividing the inflated allowable Medicaid outpatient variable costs by the total Medicaid outpatient occasions of service for the hospital excluding occasions of service for laboratory and pathology.

   b. The target rate by inflating the variable cost rate in the previous rate period by the target inflation factor calculated in V.A.8.b. above in establishing target ceilings. This target rate shall not apply to rural, specializd, statutory teaching, Community Hospital Education Program (CHEP) hospitals, and those hospitals defined in Section V.A. 9 and 10.

6. Set the rate for the hospital as the lower of the result of Step 5. above, the reimbursement ceiling in V.A.8 for the county in which the hospital is located, or the result of inflated Medicaid outpatient charges divided by total Medicaid outpatient occasions of service excluding charges and occasions of service for laboratory and pathology.

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7. Hospital outpatient rates set under plan provisions for the July 1, 2003 rate semester will be effective October 1, 2003.

8. Effective July 1, 2004 through June 30, 2005, each outpatient rate shall be reduced proportionately until an aggregate total estimated savings of $14,103,000 is achieved. In reducing hospital outpatient rates, rural hospitals and hospitals with twenty thousand (20,000) or more combined Medicaid managed care and fee-for-service inpatient days shall not have their outpatient rates reduced below the final rates that are effective on June 30, 2004. The 2002 Financial Hospital Uniform Reporting System (FHURS) data shall be used to determine the combined inpatient Medicaid days.

VI. Payment Assurance

The State shall pay each hospital for services provided in accordance with the requirements of the Florida Title XIX State Plan. The payment amount shall be determined for each hospital according to the standards and methods set forth in the Florida Title XIX Outpatient Hospital Reimbursement Plan.

VII. Provider Participation

This plan is designed to assure adequate participation of hospitals in the Medicaid Program, the availability of hospital services of high quality to recipients, and services which are comparable to those available to the general public. This is in accordance with 42 CFR 447.204 (2000).

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VIII. Revisions

The plan shall be revised as operating experience data are developed and the need for changes is necessary in accordance with modifications in the Code of Federal Regulations (2000).

IX. Payment in Full

Participation in the Program shall be limited to hospitals of service which accept as payment in full for covered services the amount paid in accordance with the Florida Title XIX Outpatient Hospital Reimbursement Plan.

X. Definitions

A. Acceptable Cost Report - A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents.

B. Adjusted patient days - The sum of acute care patient days and intensive care patient days as reported to the Agency for Health Care Administration divided by the ratio of inpatient revenues generated from acute, intensive, ambulatory, and ancillary patient services to gross revenues

C. AHCA - Agency for Health Care Administration, also known as the Agency.

D. Allowable Costs - An item or group of items of cost chargeable to one or more objects, processes, or operations in accordance with generally accepted accounting principles except as modified by the Principles of Reimbursement for Provider Costs, as defined in CMS PUB. 15-1 as incorporated by reference in 59G-6.010 F.A.C., and as further defined in the Florida Title XIX Outpatient Hospital Reimbursement Plan.